



The Future of Radiology and Radiology Billing

At recent RBMA sessions, I have heard a number of speakers offer their views on the direction of the radiology business. RBMA is the Radiology **Business** Management Association, so the emphasis was obviously on business direction, not clinical, though the lines between those two are beginning to blur. In today's radiology world, business issues include radiology reimbursement, radiology billing, radiology coding, radiology benefit managers, radiology's role in ACO's, etc. One caveat: I've quoted a number of speakers below but the conclusions and implications are mine, not necessarily theirs.

THE GLASS IS HALF EMPTY

Some comments and predictions are probably viewed as pessimistic by most in radiology. Clearly radiology reimbursement rates are declining. The recent ACR letter to Congress highlighted the 12 times that radiology payments have been reduced since 2006.¹ And there are fears that other payers will follow Medicare's lead and increase the pain. Despite the efforts of ACR and others, Brian Baker from Regents Health Resources has pointed out that Medpac-type direction points to substantial reductions over the next three years.

Meaningful use is another area of concern: current regulations mean Medicare reimbursement penalties by 2015 if a radiology group has not attested to Meaningful Use (MU). In May of 2012, only one radiology group in a hospital-based roundtable had made the effort to attest. An RBMA "mini-survey" in December 2012 showed 9% of respondents (which included imaging centers) had "implemented" MU with another 35% "in the process of implementing."² And a recent roundtable suggested that groups who have implemented EHRs and received MU payments either aren't sure the effort was worth the cost, or hadn't done the calculations. What is clear is that achieving MU takes substantial time, money and commitment. Which explains why most radiology groups are pleased by the "hardship exemption" in the EHR Stage 2 MU regulations. Those same regulations, however, make it clear that this is not necessarily a permanent exemption.

A year ago, Brian Baker and Josh Gray pointed out the declining volume of imaging studies over the past two-plus years (consistent with AdvantEdge analysis of client imaging trends³). More importantly, they outlined why volumes are likely to continue to decline despite demographic and other trends that should be leading to more studies. RBMA roundtable discussions and AdvantEdge client experience shows that most practices have responded to date by working harder: not replacing radiologists, working longer hours, etc. That approach has obvious limits but it does seem to reflect today's reality for many groups.

Of course, ICD-10 is still on the horizon with virtually everyone of the view that the industry needs to get on with implementation, which means continuing with system upgrades, training, etc.

And many remain concerned about how RBM's (Radiology Benefit Managers) are steering business toward lower cost facilities. Josh Gray, an analyst with the Advisory Board has described how BC/BS uses their "quality" survey

AT A GLANCE:

Radiology's challenges continue

- Reimbursement pressures
- Hospital demands

Opportunities exist

- "Win-win" health system relationships
- Marketing
- Imaging 3.0

Requirements for success

- Culture
- Proactive
- DSS/RBM
- Data

¹ [Medical Imaging Has Been Cut 12 Times Since 2006](#)

² RBMA Bulletin, May/June 2013. EHR Incentive Program Implementation Status mini-Survey. Cynthia Vervena.

³ RBMA Bulletin, September/October 2011. Reimbursement Declines Don't Need to be Inevitable. Bill Gilbert and Susan Vecchi-Cedrone.

in a way that most providers get an A grade, so that the focus ends up on costs, leading to commoditization of radiology. Though a counterpoint I heard recently from a major RBM is that payors and radiologists usually ignore the quality measures they provide, until the measures are shared with patients.

Of course, the most recent and most widely discussed current threat is perceived to be from new payment models that are driving hospitals to employ more physicians.⁴ And ACO's that are starting to restrict imaging studies as an explicit part of their cost containment objective. This despite hospital surveys that indicate radiology is one of the least likely specialties to be acquired or employed.

THE GLASS IS HALF FULL

Despite these pressures, there are success stories and clear guideposts toward the future. More than a year ago, Dr. Chad Calendine described how his practice has negotiated a "win win" relationship with one of their two local health systems. And other practices are continuing to grow through improved marketing, etc.

Recently, I heard (and have read) almost universal advice for radiology groups to "partner" with their hospital(s). But what does this mean, exactly? In one case, I heard it described as "Radiology needs to be perceived by the hospital as a well-oiled machine that is a key and valuable part of the system." Another description was "When the hospital is looking at the issues and problems it needs to solve, radiology shouldn't be on the list."

But the best descriptions I've heard say that radiology can only succeed by helping the hospital achieve its goals. For example, a radiology group can look at the hospital DRGs impacted by quality measures and find ways to help the hospital achieve them. Or (and) look at hospital issues like ICU bed turnover rate where radiology can help determine when a patient can be safely moved out of the ICU. Of course, the "holy grail" for hospitals/ACO's and the entire industry are outcomes measurements so any evidence-based information that radiology can provide to the hospital will be good for both parties.

I would point out that "partnering with the hospital" is something that groups have traditionally done in informal ways with their community hospitals. But in today's world, informal is no longer sufficient. For the future, a model to consider is one that started more than 20 years ago between Walmart and P&G. Often referred to as "supply chain integration" or "value chain integration," these two companies figured out how to change an adversarial relationship into a real strategic partnership.⁵ One example: when a P&G item crosses the Walmart scanner, Walmart systems inform P&G systems so that P&G can restock the store inventory! This was a radical idea at the time but is now commonplace in many industries.

The bottom line: independent radiology groups that survive and thrive in the "new" healthcare environment will work every day to optimize not only the health of the patients they serve but also the efficiency and effectiveness of the entire system within which they work. Other industries have made this transition during the past 20 years and it seems inevitable that radiology, and healthcare in general, must do the same.

Fortunately, the ACR has embarked on a major initiative called "Imaging 3.0" to provide the roadmap and, over time, the set of technology tools needed by radiology groups⁶.



⁴ Survey: Majority of Independent Radiologists Fear Hospital Acquisition, Becker's Hospital Review, April 12, 2012.

⁵ [Supply-Chain Integration through Information Sharing: Channel Partnership between Wal-Mart and Procter & Gamble](#), Michael Grean, P&G and Michael J. Shaw, University of Illinois at Urbana-Champaign.

⁶ ACR [Imaging 3.0, Beyond Image Interpretation](#).

CULTURE CHANGE

Of course, this transition is anything but easy. The most important barrier is culture: is your group committed to the transition and is the leadership in place? The best description of the culture change I've heard is "From the powerful individualistic culture in traditional radiology to the culture of the group and its collective results."

The signposts of the transition are appearing to many radiology groups: hospital contracts with quality and other performance metrics, ACO contracts, invitations to merge with other groups, etc. Perhaps more telling are recent examples where existing groups were replaced by two hospitals because they weren't willing to provide 24/7 coverage. One example quoted in Imaging Biz was Stamford Hospital where, after putting out an RFP and narrowing the field to three—two national teleradiology companies and one regional radiology private practice—Stamford chose a national teleradiology company to provide service because the regional practice would not offer a guaranteed turnaround time.⁷ Clearly the displaced groups weren't thinking about how they could make their hospital partner more successful.

An important part of the culture imperative is the need to be proactive. Proactive is best captured by an oft-repeated comment some have attributed to Dr. Lynn Massingale, Executive Chairman of TeamHealth, at the 2010 EDPMA Solutions Summit: "You are either at the table or on the table." While the exact role of radiology in most ACO's (to use the term generically) hasn't been determined, it is clear that radiology has a big role to play in the cost, quality and outcomes equation. Some have said that IDN's are looking to radiologists for help defining appropriateness, but that is much more nuanced than it appears on the surface. Another recent speaker mentioned a radiology group that proactively approached their hospital for ACO discussions. While the hospital isn't ready to proceed (yet), the group is now extremely well positioned. Translation: your radiology group needs to be at the ACO table. A similar conclusion was reached by the ACR® Future Trends Committee which recently published a whitepaper about ACO's and radiology.⁸

HOSPITAL RELATIONSHIP MODELS

The other "table" is your formal relationship with the hospital. Conventional thinking sees two options: independent group or employee. But this is far too limiting. At a recent RBMA session titled "The Captive LLC: Gaining Strategic Hospital Alignment While Retaining Independence," we heard about a spectrum of options. Just as important was the strong recommendation to maintain the group's legal identity, even if the hospital insists on a very close relationship. Several reasons were cited, including a fallback position if the "marriage" doesn't work out.

The spectrum starts with a traditional contract, then moves to co-management, then to a captive PC or LLC and finally to employment. A key part of being proactive is to understand how much, and what type, of control your hospital/health system needs and then adjust the group's governance to match.

There are easier, short-term steps to be taken as well. At the RBMA Summit in 2012, Mike Suddendorf described how to link your practice's marketing efforts with that of your health system and hospital(s). He offered practical ideas that no group should overlook: e.g. quarterly meetings with hospital marketing and PR leaders, coordinated promotional efforts, etc. And some groups are adjusting their work to better match their customer (the hospital) requirements. For example, one group described adjusting their prime shift to later in the day because 60% of their work comes in after 3 PM.

⁷ ImagingBiz, [A Cure for Commodization](#), May 27, 2013.

⁸ Journal of the American College of Radiology, Strategies for Radiologists in the Era of Health Care Reform and Accountable Care Organizations: A Report From the ACR Future Trends Committee. <http://www.imagingbiz.com/articles/view/value-based-purchasing-from-theory-to-practice>

RBM's

One critical area for attention in this transition is to turn the RBM "steering" debate on its head and figure out how to help your collective value chain determine when an imaging study is required, and when it is not. Decision Support Systems (DSS) have been promoted as a sophisticated way for referring physicians to determine when and what type of test to order. The rules that these systems will need are far from determined. And most current efforts have a limited scope, though one or two advanced systems were mentioned but not described. But since this type of system is essential for the future (and radiologists have always been at the forefront of computer technology in medicine), it is an essential area for radiologists to be proactive. Of course, this means your radiology group must work with your hospital and with your referring physicians plus others in your value chain (e.g. payers, ACO, patients, etc.). This work can't be done from the reading room!

In one recent session, the speakers said that part of becoming an indispensable partner to your hospital and value chain may, in fact, be to take over the RBM role!

DATA

Except for the culture dimension, every aspect of our industry transition depends on data. Quality and cost metrics affect radiology reimbursement and quality and cost metrics affect hospital reimbursement. Of course, the most important measures are patient outcomes. Unfortunately, most radiology groups, hospitals and health systems have not been able to establish this type of measure, yet. But there are positive steps. First is the opportunity (really the requirement) for the radiologist to have access to more information. EMR's mean that the radiologist can (and should) have the patient's entire history at their fingertips when they are reading and completing their report. The next step, enabled by ICD-10 and outcomes measures, means that a radiologist should (must) know how accurate their diagnoses are across a population of patients and within a type of test or particular diagnosis. Using this feedback can only improve results for each radiologist and it will obviously lead to continuous improvement in DSS logic. But the biggest beneficiary will be the patient: with more accurate diagnoses and testing only where required.

Data is also essential in the hospital/health system/ACO relationship. Many have repeated Edward Deming's "If you can't measure it, you can't manage it." This means contracts and relationships, of any type, must start with data that is both available and valid.

Another dimension of data is that practices today have much more data than they are aware of and it is time to start leveraging it. Everyone knows that reimbursement trends mean only one thing: radiology practices need to get much more efficient. As other industries have gone through similar transitions, a whole set of quality and cost improvement tools evolved, which are now available to radiologists and the healthcare industry. Generally referred to as Six Sigma and/or Lean, they start with simple mantra: "measure it, publish it, and it will improve." From a baseline, the next step is to Plan a change (improvement), Do it, Check (measure), then Act (adopt or reject the change). Rinse and repeat. This is the well-known Deming cycle: PDCA.

In order to use the wealth of data available, the group will need to adopt a Business Intelligence tool that can pull everything together: billing information, financial information, RIS, PACS, phone systems, equipment vendors, other vendors, etc. While this requires an investment in technology and/or working with the right business partners: you have much more information than you think and you need to be using it to drive costs down dramatically and improve quality and results.

IMPLICATIONS FOR RADIOLOGY CODING AND RADIOLOGY BILLING

Given these trends, what is going to happen to current radiology coding and radiology billing services, processes, systems, etc.? It may appear that the short term answer is: "not much." And it is very clear that the longer term answer is: "a lot." With ACO's, etc. still ramping up, the billing process won't change much for at least a year or two. And at that point, the "shared savings" calculations will probably be an overlay or retrospective analysis. In the meantime, certain "bundled payments" may impact radiology more. The CMS Acute-Care Episode (ACE) demonstration project has progressed enough that CMS can now show savings for certain high-cost Medicare Severity DRGs (MS-DRGs), such as hip replacement and heart-valve replacement. Radiologists involved in these "demonstrations" will need to negotiate their portion of the overall bundled payment, ideally in a way that shows how radiology helped save money on the entire DRG.

In the short and medium term, quality measures are certainly becoming more important, with PQRS as the tip of the iceberg. It is shocking to me that only 24% of radiologists qualified for PQRS incentives in 2010!⁹ Knowing your practices quality and cost data can help you with your hospital. You should be able to relate your performance to their Core measures. You can bet that insurers are benchmarking radiologists on per capita and per episode costs: best if you know how your practice stacks up. MU measures and capabilities are also becoming much more important: both to capture data and, equally important, to share radiology data upstream (e.g. referring physicians and DSS) and downstream (patients, referring physicians, public health agencies, etc.). This means today's "simple" process of radiology billing is going to become much more data and technology-intensive and will begin to blur the lines between radiology billing information and clinical information. Radiology coding must support the various quality measures and evolve to incorporate ICD-10 (essential for the type of outcomes measures that our healthcare system needs).

The message for radiology billing companies and radiology billing organizations seems clear: we are going to be dealing with much more data while seeing intense pressure on costs and efficiency. In other words, we are going to be asked to do more for less, just like our radiology clients. Some may see this as a negative trend but other industry's experience shows that companies who step up to the challenge not only succeed but become stronger and more successful. The question: is your radiology billing service able to respond to these challenges?

⁹ Healthcare Informatics, [Most Physicians Do Not Meet Medicare Quality Reporting Requirements](#), January 8, 2013.